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ABSTRACT

This final report discusses the activities and outcomes of a 3-year project designed to replicate a uniquely successful training model for involving physicians in community early intervention systems. The Caring for Infants and Toddlers with Disabilities: New Roles for Physicians (CFIT) model includes three replicable components: state planning, introductory seminars, and independent study. In state planning, a state leadership planning group composed of early intervention personnel, physicians and pediatricians, and other key personnel, worked with project staff to plan the replication process in their own states. Following the state planning, the CFIT seminars introduced pediatricians and family physicians to the concepts of a community-based, interdisciplinary, interagency early intervention approach, to family-centered services, and to the CFIT independent study process. The model was replicated in seven states and territories from October 1, 1997, through September 30, 2000, and trained 964 physicians. Evaluation data have provided strong evidence of the efficacy of the model in increasing both pediatricians' and family physicians' knowledge and competency as members of early intervention teams. The goals and objectives of the project, theoretical framework, problems encountered, evaluation, and impact are discussed. Appendices include CFIT competencies, independent study manual introductory materials, and evaluation measures. (Contains 13 references.) (CR)

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Caring For Infants and Toddlers with Disabilities: New Roles for Physicians

FINAL REPORT

Early Childhood Team
Research to Practice Division
Office of Special Education Programs
U.S. Department of Education

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II. ABSTRACT

Caring for Infants and Toddlers with Disabilities:
New Roles for Physicians (CFIT) Outreach Project

"This well planned and comprehensive project provides pediatricians and family physicians with a better awareness and understanding of our statewide early intervention system."
A State Part C Coordinator

Caring for Infants and Toddlers with Disabilities: New Roles for Physicians (CFIT), was designed to replicate a uniquely successful model that addressed the almost universal challenge in early intervention of involving physicians in community early intervention systems. The CFIT model includes three replicable components: State Planning, Introductory Seminars, and Independent Study. The model was developed by Child Development Resources, Norge, VA, (CDR), in collaboration with the Virginia Academies of Pediatrics and Family Physicians and colleagues at the University of Virginia School of Medicine in response to training needs identified through a survey of physicians (Scott, 1990) and families (Child Development Resources, 1989). CFIT was replicated in seven states and territories from October 1, 1997 through September 30, 2000. Evaluation data have provided strong evidence of the efficacy of the model in increasing both pediatricians' and family physicians' knowledge and competency as members of early intervention teams.

In state planning, a state leadership planning group (LPG) composed of Part C personnel, physicians representing state chapters of the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP) , and other key personnel worked with project staff to plan the replication process in their own states.

Following state planning, the CFIT seminars (Introductory Seminar) introduced pediatricians and family physicians to the concepts of a community-based, interdisciplinary, interagency early intervention approach; to family-centered services; and to the CFIT Independent Study process. The training curriculum was approved for continuing medical education credits by the University of Virginia School of Medicine, the American Academy of Pediatrics, and the American Academy of Family Physicians.

Training methodology was designed to be as individualized, self-directed, and self-paced as possible, and to acknowledge the special difficulties physicians can have in finding time for in-service training. The content of the Independent Study was based on competencies developed by the AAP (AAP, 1988) and adapted by the project. The Caring For Infants and Toddlers with Disabilities: A Manual for Physicians, 3rd Edition, was revised to comply with Part C regulations and is customized to reflect each replication state's early intervention policies. Four accompanying audiotapes cover the competency areas. Nine hundred sixty four physicians have participated in CFIT training in the seven replication states and territories.

As stated above, efficacy data have provided strong evidence of success in achieving the project's three major goals:

Goal 1	*To collaborate with Part C lead agency personnel and state chapters of the American Academies of Pediatrics and Family Physicians to plan and implement CFIT model replication activities in six to nine states.*
Goal 2	*To replicate the CFIT model of training with physicians leading to their increased knowledge and skills regarding family-centered early intervention services for children with disabilities.*
Goal 3	*To promote awareness and replication of the CFIT model and its products through dissemination activities.*

Information about replication of the CFIT model is available from CFIT Physicians, Child Development Resources (757-566-3300) or e-mail through the CDR website (www.cdr.org).

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IV. CFIT GOALS AND OBJECTIVES

Goal 1: To collaborate with Part C lead agency personnel and state chapters of the American Academies of Pediatrics and Family Physicians to plan and implement CFIT model replication activities in six to nine states.

Objectives:

1.1 To establish and/or maintain working relationships with state agencies or state chapters of AAP and AAFP requesting outreach assistance.

1.2 To use a state leadership group to plan replication of the CFIT model.

1.3 To develop a CFIT replication plan with the state Leadership Planning Group (LPG) specifying project and state responsibilities.

1.4 To provide information about the project to lead agency personnel responsible for the Comprehensive System of Personnel Development (CSPD).

1.5 To work with NECTAS to identify other states interested in replicating the CFIT model during years two and three.

Goal 2: To replicate the CFIT model of training with physicians leading to their increased knowledge and skills regarding family-centered early intervention services for children with disabilities.

Objectives:

2.1 To work with the state Leadership Planning Group to customize the independent study manual.

2.2 To assist the state Leadership Planning Group in identifying interdisciplinary panels that include parents.

2.3 To facilitate the preparation of the interdisciplinary panels to conduct the Introductory Seminars.

2.4 To provide assistance to the state LPG in implementing Independent Study.

2.5 To provide follow-up consultation and technical assistance to the state LPG.

2.6 To evaluate the CFIT outreach replication process.

Goal 3: To promote awareness and replication of the CFIT model and its products through dissemination activities.

Objectives:

3.1 To revise and produce project awareness materials, incorporating the use of electronic communication technology.

3.2 To revise project products in response to changing federal legislation and emerging communication formats.

3.3 To disseminate information about the CFIT model, outreach activities, and project products to state and national audiences.

V. THEORETICAL FRAMEWORK FOR PROJECT APPROACH

Congress, recognizing that the complex needs of infants and toddlers with disabilities cannot be met by a single discipline or agency, called for states to plan interagency, community-based, coordinated, family-centered systems of care through Part C of the Individual with Disabilities Education Act (IDEA) -- systems in which physicians' participation is essential. Physicians' offices are critical entry points to services designed to foster children's medical, social, and intellectual development (Young, Davis, Schoen, & Parker, 1998). The opportunity for children and families to receive early intervention services is, to a large degree, dependent on physicians who are alert to a wide variety of developmental problems and are aware of where to find services needed by children and families (Scott & Garland, 1994). The physician is frequently the first professional from whom parents seek advice when they have concerns about their child's development and whom they trust to provide information about their child's development (Scott & Garland, 1992). However in most busy pediatric practices, particularly within the time constraints of managed care in the last decade, there is little emphasis on

screening and early detection of developmental delays. As reported by Blackman, Healy, and Ruppert (1992), only 15-20% of pediatricians routinely administer screening tests to more than 10% of their patients.

Families have, for decades, reported the problems they have encountered when their physicians' referrals for early intervention have not been timely; when physicians have not fully shared information or perceived families as part of the decision-making process; when information and care have been provided without the emotional support families have needed; and when health care and development are not integrated within the early intervention system.

There is little doubt on the part of medical and other early intervention professionals of the need for physicians to participate in the early intervention system at both the system design and service delivery levels. Physicians serve on most state ICCs (Shackelford, 1997; Personal Correspondence, 1999) reflecting the perceived importance of their role in early intervention systems planning. At the service delivery level, both legislation and recommended practice promote a strong role for health care professionals on the early intervention team. The comprehensive developmental needs of infants and toddlers with disabilities cannot be adequately addressed without also recognizing their medical/health and family support needs (Von Rembow & Sciarillo, 1993). The medical information a physician can provide to families and to other early intervention team members is often critical to the accurate assessment of children's development and an appropriate Individualized Family Service Plan (IFSP). Likewise, families and other early intervention team members can provide the physician with information regarding children's development that is a crucial component of routine health supervision. For children with severe disabilities and /or significant health impairments, the importance of this

collaboration is heightened.

In order for physicians to assume their new roles as partners in providing community-based, interdisciplinary early intervention services, they must (1) be familiar with the provisions of Part C legislation, (2) understand the nature and importance of early intervention services, and (3) understand their role within the system of services (Wenger et al., 1989). However, the literature suggests that physicians are typically not prepared by their medical training with the knowledge and skills they need to be active participants in the early intervention service system.

As early as the 1950s, the American Academy of Pediatrics (AAP) became concerned with inadequate physician training in early childhood development, working with children with disabilities, and communicating effectively with families (Coury, 1990). In 1978, the AAP sampled seven thousand pediatricians regarding their pediatric training. Respondents reported an underemphasis on developmental aspects of pediatrics, community pediatrics, and handicapping [*editor's note: "handicapping" is term used at the time of publication by Dr. Cooley*] conditions (Cooley, 1994). Although the AAP's report (1978) recommended changes in pediatric training and many curricula were enhanced to address these deficiencies, when Wender, Bijur, and Boyce (1992) used an almost identical survey with three thousand pediatricians who completed their residency training after 1978, they found "little change in the high number of pediatricians who perceived that they had received insufficient training in areas similar to the 1978 report" (Cooley, 1994, p. 113).

Opportunities for physicians to acquire the information and skills to prepare them for their new early intervention roles and responsibilities, although clearly needed, have been limited in both number and scope. In 1986, the AAP, a leader in providing medical education

programs, operated Project Bridge, in-service training for pediatricians in decision-making as part of community early intervention teams. Some state chapters of the AAP had also begun training initiatives. In 1991, the Arizona chapter of the Academy developed a collaborative training model aimed at ensuring that every child who had, or was at risk of having, a disability was identified and treated appropriately. In 1990, after the American Academy of Family Physicians (AAFP) resolved to make training in what was then called Part H a priority, the Ohio chapters of AAP and AAFP co-sponsored a project to familiarize pediatricians, family physicians, and office nursing staff with Ohio's plan for implementing the current legislation governing services to infants and toddlers with disabilities, P.L. 99-457. The results of this project included building collaborative relationships at the state and local level among physicians, early intervention providers, and families. Other states have used broad dissemination strategies to provide physicians with information about children with disabilities. Still, despite initiatives by their professional organizations, many physicians remained unaware that Part H existed, let alone that the law had implications for their professional practice (Cohen, Kanthor, Meyer, & O'Hara, 1990). Blackman, Healy, & Ruppert (1992) described results of a statewide survey of pediatricians conducted by the New York State American Academy of Pediatrics District II in which only 15% of the respondents felt well informed about Part H, and only 8% saw themselves as being involved in the development of IFSPs.

There was a great deal of evidence that physicians not only needed, but wanted, training to enable them to be full participants in systems of comprehensive early intervention services (Melmed, 1991). The New York survey, cited above, revealed that 80% of the respondents desired more information about the law. While the CFIT model adapted some earlier, successful

strategies for physician training for learning about children with disabilities, none of the projects thus far had the broad focus of the CFIT model, i.e., ***to increase the competencies of the physician related to participation in community-based services.*** As the challenges of implementing coordinated, interdisciplinary, family-centered systems of early intervention services increased, particularly with the sweeping changes resulting from managed care, there was an urgent and unmet need for a proven model of in-service training to prepare physicians for their roles as members of community early intervention teams. Without proven models for in-service training for physicians, the intent of the legislation to provide quality services for young children with disabilities and their families would be seriously impaired. The CFIT model responded to a need which might be described in medical terms as both chronic and severe.

The CFIT model addressed an urgent and compelling need perceived by parents, physicians, and other early intervention providers. The CFIT model of training has proven, through a prior demonstration project, to be effective in increasing both pediatricians' and family physicians' knowledge and competency as members of early intervention teams. The outreach training model was designed to accommodate several concerns of the physicians who participated in model development. In order to ensure physician participation in training, they determined that the CFIT outreach training must:

- be appropriate to physicians who had varied levels of information and interest,
- be delivered in a format that makes good use of physicians' time and varied training needs,
- be offered with continuing medical education credits, and
- include physicians in curriculum design and instruction.

The CFIT training content was thus based on a set of competencies developed by the American Academy of Pediatrics (AAP, 1988) and adapted by the project (Appendix A, CFIT Competencies). Training methodology, which incorporated independent study, was designed to be as individualized, self-directed, and self-paced as possible, and to acknowledge the special difficulties physicians might have in finding time for in-service training.

The CFIT model included three replicable components (which will be described further in Section VI. Description of CFIT Outreach Model): **State Planning, Introductory Seminars, and Independent Study**. Successful model replication was ensured by the **State Planning** process. In each of the states in which the project operated, leadership planning groups (LPGs) comprised of key stakeholders, including physicians, families, and other early intervention leaders, worked with project staff to facilitate the replication process and to plan CFIT training for physicians in that state. Training included regional Introductory Seminars and Independent Study supported by the independent study manual and four audiotapes. The project offered continuing medical education (CME) credits giving credibility to the training and promoting physician participation (Appendix B, Accreditation Statements).

VI. DESCRIPTION OF CFIT OUTREACH MODEL

A. Description of CFIT Outreach Process

The purpose of CFIT Outreach was to increase physician participation in early intervention systems through replication of a proven model of training. This model was developed in response to the need for physicians to be active participants on early intervention teams. CFIT was developed in collaboration with physicians who served on Virginia's ICC, the state chapters of AAP and AAFP, colleagues at the University of Virginia (UVA) School of

Medicine, and families of children with disabilities. The curriculum was based on competencies regarding early intervention developed by the AAP and adapted by the project (Appendix A, CFIT Competencies). CFIT training has been approved for continuing medical education (CME) credits (Appendix B, Accreditation Statements). The model was developed between 1991-1994 and used in seven regions of Virginia. Data on efficacy of the model and of model replication in other states are discussed in Section VIII. The CFIT model included three replicable components: **State Planning, Introductory Seminars, and Independent Study**. These components are described in detail in the description of model replication (pp.9-13).

CFIT outreach design included a **four step process: CFIT Site Selection, Replication of CFIT Components, Technical Assistance to Replication Sites, and Evaluation** (Figure 1). A description of each step in the outreach design follows.

Figure 1. Four step outreach process

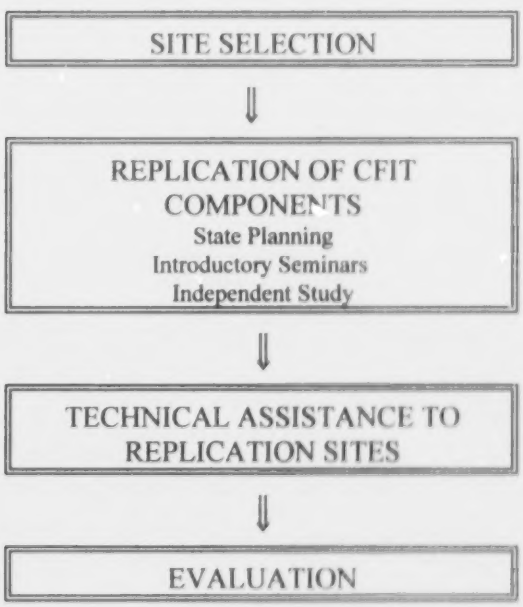
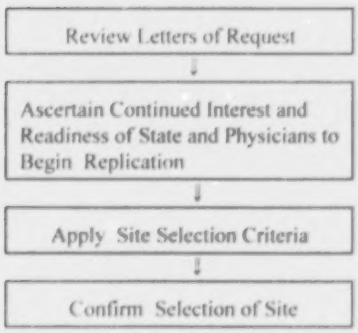


Figure 2 (p. 9) presents the methods and procedures for **STEP 1: SITE SELECTION.** The project began site selection by reviewing letters of request from six states, submitted with the proposal application. The project used well-developed criteria (Appendix C, CFIT Site Selection) to select replication sites. This clear criteria ensured that project assistance was appropriate to the needs and resources of the state and that project activities would result in successful

Figure 2. Site selection


Review Letters of Request
Ascertain Continued Interest and Readiness of State and Physicians to Begin Replication
Apply Site Selection Criteria
Confirm Selection of Site

replication. Support of the state chapters of AAP and AAFP was critical, and selection criteria required their representation along with Part C and other key personnel as part of a leadership planning group (LPG). Other criteria required making training accessible to physicians whose patients lived in Empowerment Zones and Enterprise Communities (EZ/ECs), providing support for customizing CFIT's independent study manuals, cost sharing, and collecting data for project evaluation. In addition to CFIT Site Selection, a states' readiness to begin replication activities was also considered. States selected for replication are described in B. Replication Sites and Training Activities, p. 15. CFIT staff provided technical assistance to states as needed in order to foster conditions that would lead to successful replication.

Figure 3. Replication

STATE PLANNING	INTRODUCTORY SEMINARS	INDEPENDENT STUDY
Develop Replication Plan	Prepare Panels	Distribute Manuals and Audiotapes
Customize Manual	Conduct Seminars	Provide Support
Identify Panel Members	Provide CME Documents	Provide CME Documents
Invite Physicians		

STEP 2 in the outreach process was the **REPLICATION** of the three components of the CFIT model: **State Planning, Introductory Seminars**, and **Independent Study** (Figure 3).

State Planning. The **State Planning** component involved the development of state leadership planning groups (LPGs) composed of Part C personnel, physicians

representing state chapters of the American Academies of Pediatrics and of Family Physicians, parents, and other key personnel. State LPGs worked with project staff to plan and implement the replication process in their own state.

The state LPG developed, with CFIT support, a written action plan for training. This plan included tasks to be completed, roles and responsibilities of CFIT staff and LPG members, timelines for accomplishing tasks, and procedures for evaluation data collection (Appendix C, LPG Action Plan). The relationship between CFIT and the LPG was formalized through a signed outreach replication agreement (Appendix C) in each replication state.

Together CFIT staff and LPG members gathered information on state Part C policies and procedures and state and local resources to use in customizing the independent study manual; implemented a process for identifying physicians, other early intervention providers, and parents to serve as panelists for the regional introductory seminars; and determined the number, time, and location of seminars, ensuring full accessibility. Announcements and information about the seminars were disseminated to physicians, other early intervention providers, and parents. With the assistance of the state chapter representatives of AAP and AAFP on the LPG, invitations to community physicians to attend the seminars were issued using academy mailing lists. Key representatives of both academies also provided letters of endorsement for the customized independent study manuals in each state. In response to the Secretary's competitive priority, special attention was given to reaching physicians who cared for children in EZ/ECs.

After the logistical planning and selection of panelists for the seminars was completed by the LPG, project staff helped the LPG to prepare those panels during a train-the-trainer event. This training provided panelists with information about the CFIT curriculum, modeled the panel

presentation, and provided opportunities for discussion and planning their regional seminars. Physician panelists were given the CFIT independent study manuals to complete prior to their participation in the regional introductory seminars.

Introductory Seminars. The CFIT course sequence was designed to move the learner from acquisition of prerequisite knowledge to mastery of knowledge and skill. Table 1 (p. 12) outlines the course sequence by outcome, purpose, method, instructional technique, instrumentation, and time. The three-hour regional **Introductory Seminars were the second component of the CFIT model**. The seminars laid the foundation for subsequent learning and introduced physicians to the concept of a family-centered team approach to early intervention services and to the CFIT independent study process. The structure of the seminar was planned during model development in collaboration with physicians, parents, and state early intervention program representatives. A panel presentation was used to create a shared understanding of the role expectations each early intervention team member (physician, other early intervention provider, and family member) has of the others, particularly during the processes of **child find**, **assessment**, **IFSP**, and **transition**. Panelists presented information from their diverse perspectives and engaged physicians in discussion. Physicians also received information about how their local early intervention system works and had a chance to meet local early intervention service providers, increasing their awareness of community resources (Appendix C, Introductory Seminar Agenda).

TABLE 1. Course sequence

INTRODUCTORY SEMINAR OUTCOME: An understanding of the need for competency-based training based on the change in physicians' roles as a result of Part C of IDEA and increased commitment to project participation.

PURPOSE	METHOD	INSTRUCTIONAL TECHNIQUE	INSTRUMENTATION	TIME
To provide an overview of the roles of physicians with regard to: **child find**, **assessment**, **IFSP**, and **transition**	• Group Training	• Interdisciplinary Panel • Group Discussion • Networking	• Introductory Seminar Evaluation	3 Hours

INDEPENDENT STUDY OUTCOME: A strong knowledge base in each of the four competency areas.

PURPOSE	METHOD	INSTRUCTIONAL TECHNIQUE	INSTRUMENTATION	TIME
To provide detailed information about **child find**, **assessment**, **IFSP**, and **transition**	• Individual Learning	• Written Materials • Audiotapes	• Physician Knowledge Pre/Post Measure • Physician Competency Pre/Post Measure • Independent Study Manual and Audiotapes Evaluation	3 Months

Regional seminars were held at convenient times (evenings, breakfasts, luncheons) and locations (hospitals, restaurants, agencies serving children with disabilities), with emphasis on ensuring accessibility to physicians who cared for children in EZ/ECS, selected by the LPG. Physicians left the seminars with their independent study manuals, audiotapes, and certificates of attendance that were used to obtain CME credits for the Introductory Seminar.

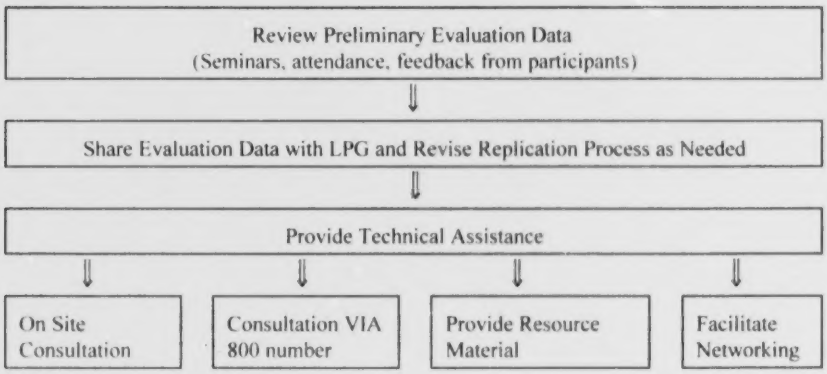
Independent Study. Independent Study, the third and final component, was designed to be individualized, self-directed, and self-paced and to acknowledge the difficulties physicians have in finding time for in-service training. The content of the Independent Study was based on the competencies developed by the AAP and adapted by the project. Competencies addressed the four early intervention processes in which physicians' participation is particularly important:

child find, assessment, IFSP, and transition. The CFIT manual, customized to reflect each state's early intervention policies and procedures, was indexed to competencies in those four areas so that physicians could locate content based on their areas of greatest interest and need. The 400 page, 9 section manual (Appendix D, Independent Study Manual Introductory Materials), reviewed and approved as part of the process of awarding CME credits for independent study, included practice activities, supplemental readings, and contacts for referral to early intervention services throughout the state. Four accompanying audiotapes covered the four competency areas and were used as a preview or summary of the reading material.

During the three months that physicians participated in the independent study component of CFIT training, they were able to contact resource persons for technical support in understanding and integrating the new information into practice, having received introductions and contact information at the introductory seminars. Upon completion of their post-training measures, physicians received a Certificate of Completion which generated their CME credits for independent study.

The outreach process continued with a 6-12 month **Technical Assistance** relationship with the replication state following the first Introductory Seminar (Figure 4, P. 14). During this period, CFIT staff provided technical assistance to the LPG for planning additional regional seminars and collecting evaluation data. This assistance included on-site consultation or consultation via telephone and electronic communications. CFIT staff provided information and assistance on continuing replication strategies and resource materials. When appropriate, CFIT staff extended the project capabilities by connecting the LPG and physicians with state and

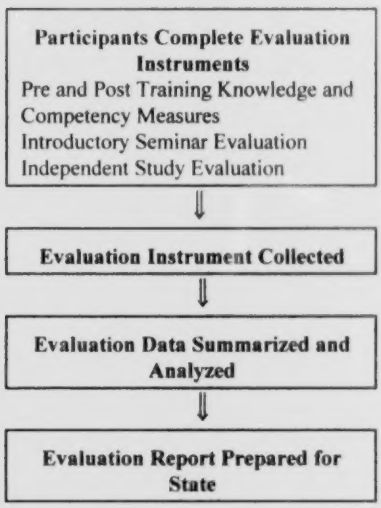
Figure 4. Technical assistance to replication site


Review Preliminary Evaluation Data
(Seminars, attendance, feedback from participants)
Share Evaluation Data with LPG and Revise Replication Process as Needed
Provide Technical Assistance
On Site Consultation
Consultation VIA 800 number
Provide Resource Material
Facilitate Networking

national training and technical assistance resources such as UAPs and other OSEP projects.

STEP 4 (Figure 5) in the Outreach process was the **EVALUATION** of project impact. The project used several measures to evaluate efficacy of training both within a replication site and across sites. Change was measured and analyzed using the Physician Knowledge Measure and the Physician Competency Measure (Appendix E), developed to assess these areas pre/post training. Both measures assessed the overall impact of the training as well as gains within the specific subdomains of Child Find, assessment, IFSP, and transition. Participants also completed two rating scales, the Introductory Seminar Evaluation and the Independent Study Manual and Audiotapes Evaluation, to rate perceived quality, usefulness, and overall satisfaction (Appendix E). Data from these analyses and quantitative information regarding numbers of introductory seminars held and numbers of physicians participating are summarized and provided in Section VIII.

Figure 5. Evaluation


Participants Complete Evaluation Instruments
Pre and Post Training Knowledge and Competency Measures
Introductory Seminar Evaluation
Independent Study Evaluation
Evaluation Instrument Collected
Evaluation Data Summarized and Analyzed
Evaluation Report Prepared for State

B. Replication Sites and Training Activities

Project staff selected replication sites as discussed on pp. 8 and 9 using Criteria for Site Selection (Appendix C). Replication activities were conducted in the following seven states/territories:

- District of Columbia
- Illinois
- Mississippi
- Nebraska
- Oklahoma
- Texas
- U.S. Virgin Islands

The total number of physicians who participated in CFIT training was 964. The table below (TABLE 2) summarizes the major outreach activities implemented in each state.

TABLE 2. Outreach activities

State	*LPG Meetings*	*Train the Trainer*	*Introductory Seminars*
District of Columbia	*3*	*1*	*2*
Illinois	*2*	*2*	*7*
Mississippi	*2*	*1*	*4*
Nebraska	*4*	*2*	*13* *7 additional locations broadcast by telemed*
Oklahoma	*3*	*2*	*5*
Texas	*2*	*1*	*7*
U.S. Virgin Islands	*2*	*2*	*2*
Totals	*18*	*11*	*47*

CFIT staff worked with state leadership planning groups to plan and implement CFIT training in seven states and territories. A key state planning task was the gathering of Part C policies and procedures and resource information for use in customizing the CFIT independent study manual. A total of one thousand seven hundred (1,700) independent study manuals and audiotapes, **Caring for Infants and Toddlers with Disabilities: A Manual for Physicians**, were customized, produced, and shipped by request to the seven states to support independent study.

LPG members in all replication sites identified providers of health care for children from the following enterprise communities or empowerment zones (Federal Register, January 21, 1997):

- District of Columbia
- Dallas, TX
- Chicago and Springfield, IL
- Oklahoma City, OK
- Omaha, NE
- Jackson, MS
- U.S. Virgin Islands

Train-the-Trainer Seminars were adapted to meet the varied needs of the selected sites. In Illinois, Oklahoma, Nebraska, and the U.S. Virgin Islands, train-the-trainer seminars were held in two locations to accommodate those who needed to travel great distances. In Oklahoma and Nebraska, the train-the-trainer seminars were repeated in years 2 and 3 to train new panelists. In total, 11 Train-the-Trainer Seminars were conducted during the three years of project operation.

The **Introductory Seminars** introduced physicians to the concepts of a community-based, interdisciplinary, interagency early intervention approach to family-centered services and to the Independent Study. Action Plans for each site were highly customized to accommodate the varied geographic and demographic needs of the target audience of physicians. For example, in

Nebraska, a state with extreme distances to travel outside of the two major cities, the CFIT seminars were telecast using the Telemed Network, and the CFIT liaison for the LPG made visits to individual physicians in outlying rural areas. This strategy for reaching rural physicians was also provided in Oklahoma, and the CFIT staff facilitated technical assistance between the Nebraska and Oklahoma CFIT liaisons (Oklahoma is considering telecast seminars for a third year of training scheduled for Spring, 2001). Approximately 964 health care professionals participated in 47 introductory seminars and/or independent study in seven states and territories (District of Columbia, Illinois, Mississippi, Nebraska, Oklahoma, Texas, and the U.S. Virgin Islands).

As stated in the CFIT model description, a key component of CFIT training is **independent study**. Typically physicians receive independent study materials at the Introductory Seminars and have a suggested three months to complete their study. This format was followed in all states. In addition, in Nebraska, Illinois, and Texas, a small number (under 10%) of physicians who were not able to attend the seminars were provided with the Physicians Manual and Audiotapes by mail and completed only that component of the training.

Technical assistance has been provided with CFIT liaisons in all states. Continuing technical assistance has been provided via the CFIT 800 telephone number and electronic mail. Problem-solving around increasing return of evaluation data and the implementation of seminars in follow-up years are major topics of discussion. Nebraska, Oklahoma, U.S. Virgin Islands, and Illinois have all continued training in subsequent years following their initial cycle of Introductory Seminars and Independent Study. District of Columbia will complete their initial cycle of Introductory Seminars in March, 2001. Oklahoma has received follow-up funding to

continue introductory seminars in spring, 2001. This continuation of training has resulted in updates and/or revisions of the state's customized manuals, additional train-the-trainer seminars in selected states (when original panelists are no longer available), and follow-up data collection. States are requested to provide follow-up evaluation data on physicians in subsequent training cycles. Additional technical assistance has included the provision of resource material on developmental screening provided on loan, articles on early intervention efficacy, information regarding Medicaid teleconference, and child find strategies.

C. Dissemination Activities

The third goal of the project was to promote awareness and replication of the CFIT model and its products through dissemination activities. These activities included revising and producing project awareness materials; incorporating the use of electronic communication technology; revising existing materials to comply with reauthorized federal laws and new communication formats; and disseminating information about the model, outreach activities, and project products to state and national audiences. A variety of strategies were used to meet this goal.

Revision and Production of CFIT Materials

The project **Identity Packet** was refined to include the CFIT 1997-2000 abstract, sample materials, and a description of replication criteria and process, including targeting physicians who serve children and families in EC/EZs and cost sharing.

CFIT information was developed for a project **display board** used at outreach fairs, poster sessions, and other dissemination events.

The **Caring for Infants and Toddlers with Disabilities: Manual for Physicians** was revised to comply with the reauthorization of Part C of IDEA. In addition to content revisions, the manual was reformatted to reflect a more user-friendly style, revised self-study activities, and a redesigned cover. Additional resources were identified for the manual including selected readings and updated screening and assessment instruments, and family stories were developed and included in the text.

The **CFIT Physicians Audiotapes**, included in the manual, were revised in response to evaluation data. The four new audiotapes included family story dialogues between physicians, families, and other early intervention providers. The revised audiotapes also reflected the changes in Part C of IDEA.

Information about the CFIT model, outreach services, and sample CFIT products were submitted to NECTAS for inclusion in the **NECTAS Outreach Catalogues and on the NECTAS Website.**

A **Replication Guide** was developed to support state LPGs in procedures for replication of the training. The guide contains sample hard copies and disk templates for use in developing letters of invitation, brochures, agendas, and logistics checklists for conducting LPG meetings, Train-the-Trainer Seminars, and Introductory Seminars.

Resource materials for replication sites were packaged as:

- **LPG Workbooks (1 & 2)**
- **Train-the-Trainer Workbook**
- **MD Leader Speaker's Notes**
- **Facilitator's Guide for LPG Meetings**
- **Facilitator's Guide for Train-the-Trainer Seminar**
- **Moderator's Guide for the Introductory Seminar**

All workbooks and facilitator's guides are supported by PowerPoint presentation (disks, hard copies and slides) and traditional overheads.

CFIT information (Abstract, Key Aspects of the Project, Outreach Process, Replication Criteria, and Comments from Physicians and Families) was formatted for electronic presentation on the **CFIT Physicians page of the CDR Website.**

- **State Conference Presentations**

  - Medical College of Virginia, "Peds at the Beach" Conference, July 1999, July 2000
  - Virginia Academy of Family Physicians, Summer Conference, July 1999
  - Virginia Academy of Family Physicians, Winter Conference, February, 2000

- **National Conference Presentations**

  - Zero to Three Conference National Training Institute, Washington, D.C., December, 1998
  - Zero to Three Conference National Training Institute, Anaheim, CA, December, 1999
  - DEC International Conference, Chicago, IL, December, 1998

- DEC International Conference, Washington, DC, December, 1999

■ **Other National and State Dissemination Efforts**

- CDR published a **Leadership Brochure** featuring all agency training and direct service programs. This brochure was widely disseminated, including mailing to approximately 600 recipients including all state Part C and 619 contacts, state chairpersons of ICCs, and other state agency representatives.
- Outreach information presented at the:
  - International Division for Early Childhood Conference, 1998 and 1999;
  - NECTAS/OSEP Combined Meetings, January, 1998, January, 1999, and January, 2000.
- CFIT staff were interviewed for a television talk show, aired in the U.S. Virgin Islands in 1998-99; staff also were interviewed for a radio announcement highlighting training on St. Croix and St. Thomas.
- Project staff participated in two conference calls on Child Find (1999-2000) and consulted with OSEP project offices via conference call on physician training.
- CFIT Training was highlighted on the three major television stations in Jackson, MS, August 2000.

Project staff responded to phone and written inquiries regarding project services and products from personnel in 19 states: Arizona, California, Colorado, District of Columbia, Hawaii, Iowa, Kansas, Kentucky, Louisiana, Massachusetts, Mississippi, Missouri, Montana, New Jersey, New York, North Carolina, Tennessee, Vermont, and Washington.

VII. PROBLEMS ENCOUNTERED

While program design incorporated using CMEs as incentive to physicians to return the post-training measures, the awarding of CMEs was an incentive in some states and not in others. The collection of post-training measures has remained a continuing challenge for the project.

In response to previous feedback from physicians and low return rates from physicians on post-training measures (Knowledge and Competency Post-Tests and Independent Study Manual Evaluations) the project staff, evaluation consultant, and the project's NECTAS TA provider explored strategies to increase the physician's willingness to complete the measures

and thus increase their rate of return. Three strategies have been identified for future training efforts with physicians.

- An item-analysis will be conducted by the evaluation consultant and the four page long measures will be shortened by selecting only those items that have provided information about physician change in knowledge or competency regarding early intervention service delivery. Because the efficacy of the model has been established through prior model development and outreach training data, this change in the measures will not affect the integrity of the evaluation design.
- Through consultation with physician members of the state LPGs, the use of electronic returns of evaluation measures was explored. The LPG members recommended that while some physicians may use the electronic return of evaluation measures, this would need to be offered as an option and not as an exclusive method of returning evaluations. Using support from NECTAS, a consultant was identified to examine the current measures and format the measures for use on an electronic data base, calling it "CFIT Online". This effort, while simple in theory, was challenging to implement because of hardware limitations and the technology available at the agency at the time of the design of "CFIT Online." The software program has been designed and the hardware has been upgraded to accommodate the program. Physicians who have participated in training will receive a postcard inviting them to visit the CDR website and link to "CFIT Online" to complete their evaluation measures. This method will be offered during the new CFIT Outreach Project (2000-2003).
- While the model has been successful in adapting to physicians' schedules and in reaching

a large number of physicians, feedback from physicians indicates that the three hour length of the seminar is sometimes a barrier to attendance. Project staff, the physicians involved in the original project design, and the project evaluator have explored options for altering, shortening, or identifying alternative seminar formats. Alternative formats under consideration include:

- teleconference seminars (used successfully in Nebraska);
- the establishment of a CFIT chat room to explore seminar discussion topics online;
- the development of a CFIT Seminar and Independent Study Course online;
- the development of a one-hour seminar to be presented at hospital grand rounds; and,
- the development of a one-hour information session for individual physician office visits by early intervention and family member partners to interest physicians in CFIT independent study.

VIII. EVALUATION

The efficacy of the CFIT model was originally established based upon the results of training of a group of approximately 200 Virginia physicians in 1994 and approximately 1,000 health care professionals between 1994 and 1997. Between 1997 and 2000, almost 1000 additional health care professionals in seven states and territories have received training. Pre-post data are currently available from five of those states since time for completion of independent study delays post-test data collection. Those states are: Illinois, Nebraska, Oklahoma, Texas, and the US Virgin Islands.

To measure model efficacy, three questions have been posed concerning 1) the extent to which training increased physicians' competence to fulfill their roles as members of early intervention teams, 2) the extent to which training increased physicians' knowledge about early

intervention services, and 3) the extent to which training content and materials were perceived as useful and of high quality. Data provide strong evidence of model efficacy and replicability and are summarized below.

TABLE 3. Average Rating/ Competency Measure Pre / Post Tests

Domain	States			
	Model		Other States	
	Pre	Post	Pre	Post
Child Find	2.92	4.11	3.23	4.26
Assessment	2.86	3.91	3.15	4.09
IFSP	2.48	3.92	2.76	3.64
Transition	2.39	3.81	2.91	4.06
TOTAL	2.69	3.94	3.00	3.50

Extent of Increased Physician Competency. The Physician Competency Measure examined physicians' measure of their own competence as member of e.i. teams, using the competencies developed by the AAP and adapted by CFIT. Table 3 represents the **Competency Measure data** from the original model and the training states combined data. Analysis of these data indicated that the original model increased physicians' mean competency ratings from 2.69 pre-training to 3.94 post training. Analysis of the competency measure indicated that pre vs. post training differences were significant for all 4 sub-scales. Physicians in the other training states also demonstrated gains similar to those found in the model. Differences in pre and post training competency ratings were examined in a 2 Time (pre vs. post test) X 2 State (model development state vs. combined training states) ANOVA. The results of the ANOVAs of the 4 post subdomains and total scores indicated consistent significant gains between pre and post-tests for both the model and the combined training states. **Physicians in both the original model and in other states showed significant increases in competency.**

In addition to the significant difference, for one sub-scale, IFSP Development, and for the

Total Competency score, there was a significant interaction between the time effect and the state effect. This difference indicated that the pattern of change across time was different for the model and outreach participants. The interaction is attributable to the fact that on the IFSP sub-scale and the Total scale, the outreach trainees' scores started higher and ended lower than the model trainees. Because the total score is the average of the individual scale scores, the interaction effect for the total scale is attributable to the difference in participants' IFSP sub-scale scores.

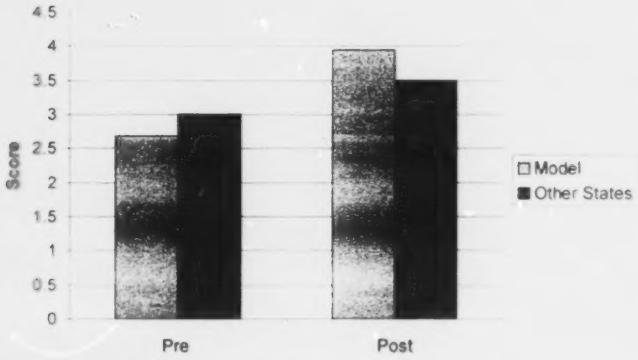


Figure 6. Comparison of Pre/Post Competency Tests

The pre to post test differences in total ratings for both the model and for the combined outreach states demonstrate that the CFIT model of training increased physicians' measure of their competency to fulfill their roles in early intervention (Figure 6).

Extent of Increased Physician Knowledge. The Physician Knowledge Measure assesses knowledge in the four areas of early intervention services. In the original model, participants scored 57.4 % correct on the Physician Knowledge Measure before training. The post-training scores showed a statistically significant increase to 74.6% correct. This change represents a 17.2% increase in physicians' knowledge and indicates that CFIT training resulted in increased physician knowledge about family-centered early intervention services for children.

Comparison of the combined results in other states to results of the original model demonstrates similar findings. Table 4 represents the scores of the model participants and scores of physicians in other states. These data were analyzed using a 2 Time (pre vs. post training) x 2 State (model state vs. combined training states) repeated measures ANOVA.

The results on the **Physician Knowledge Measure** provide strong evidence of the efficacy of CFIT training for both the original model and the training states. Total scores and scores in 3 of the 4 subdomains show significant improvements between pre and post-tests by both model participants and other states' physicians. For both groups, there initially was an approximate *45%* deficit in important knowledge about early intervention services. **The project was able to increase significantly the knowledge of all groups trained**. While the amount of change is different for these groups, the pattern of change is similar. Changes in knowledge were statistically significant for both groups across time (Figure 7).

TABLE 4. Average Percentage Correct/ Knowledge Measure Pre/ Post Tests

Domain	States			
	Model		Other States	
	Pre	Post	Pre	Post
Child Find	53.3	64.7	57.3	65.7
Assessment	60.3	80.8	58.9	71.8
IFSP	68.1	94.7	66.7	81.3
Transition	66.7	71.1	75.0	82.6
TOTAL	57.4	74.6	56.2	66.8

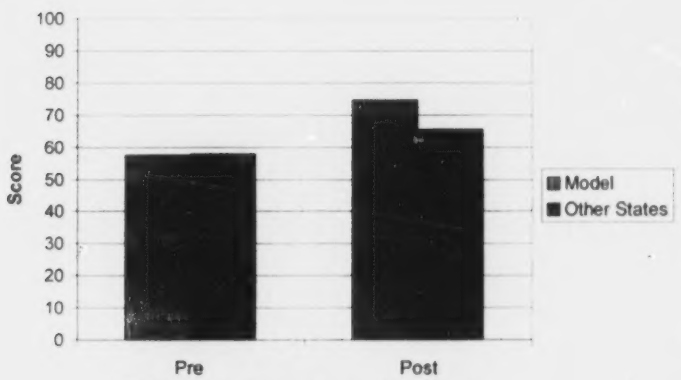


FIGURE 7. Comparison of Pre/Post KnowledgeTests

Extent to Which Training Content and Materials were Perceived as Useful and of High Quality.

Physicians participating in the CFIT training completed two rating scales to evaluate the quality and usefulness of the Introductory Seminar and the Independent Study Manual and Audiotapes. Both measures used Likert-type rating scales and yes/no questions. For both rating scales participants' ratings indicated a high degree of satisfaction with the quality and usefulness of the model and materials. The Seminar Evaluations had mean scores of 4.55 (5 being high). Ninety-four and five tenths percent (94.5%) of the respondents reported that they felt adequately involved in the discussions, and 99% felt that the seminar approach was an effective approach for learning the material. Findings on participants' satisfaction with the manual and audiotapes showed mean scores of 3.9 (5 being high). Eight-five percent (85%) of the respondents reported that they had completed the manual, with the remainder identifying that they had skimmed all chapters or studied specific chapters. Ninety-eight and seven tenths percent (98.7%) of the respondents reported that they would recommend CFIT manuals and audiotapes to a colleague. **These ratings indicate a high degree of satisfaction with the quality and usefulness of the CFIT model of in-service training and materials.**

The following statements summarize CFIT efficacy data:

- CFIT training results in increased physician knowledge about family-centered early intervention services for children with disabilities.
- CFIT training increases physicians' competence to fulfill their important role in early intervention.
- Physicians indicate a high degree of satisfaction with the CFIT model of in-service training and perceive training content and materials to be useful and of high quality.
- CFIT is a replicable model producing consistent results across sites.

Physicians' own comments best show the effects of CFIT training:

- *"This training has increased my sensitivity to parental concerns."*
- *"I didn't know I could refer without a diagnosis...gained understanding of when and how to refer...definitely will use."*
- *"...[I learned] the importance of sharing information.."*
- *"I am excited at the prospect of future impact in our area."*
- *"I will be more cognizant of transition periods and help families transition."*
- *"[I've learned] how to support the family through the process."*
- *"The program was well done - I like the different points of view, especially the parents."*

IX. CFIT PROJECT IMPACT

The CFIT Project has offered the field of early intervention a needed and proven model of training for physicians resulting in increased knowledge and competence with regard to their role on early intervention teams. Efficacy data on the project support this impact. The model has had the potential to improve services for young children and their families through this increased involvement of physicians on community early intervention teams. Evaluation data also support this significant impact. In one replication state, early intervention providers reported an increase of four times the normal referrals from physicians; within the first six months post training 78% of doctors who attended CFIT training made referrals that they would not have made without the training and 92% reported that they made referrals to early intervention sooner as a result of training (Report: Caring for Infants & Toddlers: A New Perspective for Physicians, Nebraska Early Intervention Program, Feb 2000).

Impact on Physicians. Both legislation and the beliefs of families place the physician in a leadership role in helping families identify and gain access to services their children need. If physicians are to serve as primary referral sources and to participate actively in the Part C system, they must be aware of the legislation, early intervention services available, and the benefits of those services. CFIT evaluation data provide strong evidence that the CFIT model has increased participating physicians' knowledge about early intervention services and their competence related to their role as members of early intervention teams. Approximately 964 physicians in seven states and territories benefitted from CFIT training during the 1997-2000 project period.

Impact on Children with Disabilities. For the young child with disabilities the physician is often the critical link between the family and the early intervention system. Physicians, parents, and early intervention professionals agree that early identification is important only to the extent that it links families with services. Through the CFIT model, physicians increased their knowledge about child find and the importance of referring children and their families; in fact, in response to the question on the Seminar Evaluation Form, "What have you learned... and plan to implement?", two of the most frequent comments by physicians were "Refer" and "Refer early."

Through the Introductory Seminars, linkages have been established between the community early intervention systems and physicians, promoting an increase in physician participation on community-based teams. One physician commented as a result of the seminar, "It is so great to have a face with a name, I'm going to call [Cathy] tomorrow and talk to her about a child in my practice."

CFIT has also had a positive impact on the lives of young children with disabilities and their families by increasing their access to services through strategies that specifically targeted physicians who care for children living in EZ/ECS. Enterprise Zones and Communities were targeted in individual state planning. In each state at least one seminar was conducted in an enterprise zone or community. Physicians who serve populations who live in enterprise zones and communities were invited to serve on LPGs and as panelists, and Introductory Seminars were marketed to hospitals and clinics that serve this population.

Impact on States. The CFIT Project has contributed to current knowledge and practice by providing families, physicians, the early intervention system, and the professional community at large with a proven model of in-service training for physicians that:

- promotes the involvement of physicians in community early intervention systems;
- results in physicians' increased knowledge and competence regarding family-centered early intervention services;
- is individualized, self-paced, and self-directed to the maximum extent possible;
- meets the continuing education standards of the medical community with approval for CMEs by the University of Virginia School of Medicine, the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP) (Appendix B);
- includes an independent study manual and accompanying audiotapes that can be customized for use by states throughout the country; and
- is highly replicable and has resulted -and will continue to result - in significant benefits for young children with disabilities and their families.

In Nebraska the development of partnerships has increased the number of persons receiving training, increased the number of attendee's receiving CMEs and decreased the cost of training through partnering with drug companies for support of lunch for the participants and

hospital or local medical groups sponsoring brochure development and mailing.

The important impact of the Train-the-Trainer Model cannot be overlooked in the impact on states. Most states have implemented the training well-beyond the initial 12 month agreement with CFIT for the Introductory Seminars. For example, in Oklahoma, the UAP at the University of Oklahoma has received grant funds to implement a third year of CFIT training in Spring, 2001. While CFIT does provide continuing technical assistance, the existence of the LPG and trained panels to implement seminars establishes the model as cost effective and efficient. This, along with the development of the state customized Physicians' Independent Study Manual, has ensured even greater autonomy from the project and given states the ability to implement training beyond the initial relationship with the CFIT project.

Several states (Nebraska, Oklahoma, Mississippi, Texas, and the U.S. Virgin Islands) have conducted Introductory Seminars for pediatric residents. CFIT staff recognize the need for incorporating information about family-centered early intervention services into training programs for medical professionals and consistently provided options for encouraging this effort, including modifying seminar time to accommodate the residents' schedules and permitting duplication of published CFIT materials.

X. FUTURE ACTIVITIES

A major focus of future activities will be on continued replication of the CFIT model of training. Child Development Resources has been awarded a three-year outreach grant (2000-2003) to replicate the CFIT model in 5-8 additional states. The project, CFIT Physicians Outreach, will continue to assist state leadership groups in using the CFIT model to increase the involvement of physicians in community-based early intervention systems.

The Virginia Interagency Coordinating Council continues to support CFIT training for physicians in Virginia. Under a separate contract with the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, this effort has resulted in the training of approximately 250 Virginia physicians or other health care professionals from 1998 to the present and it is anticipated that an additional 80 will receive CFIT training in 2001. The Virginia contract supported the development of a CFIT Introductory Seminar videotape that has been used successfully at Train-the-Trainer Seminars, as a refresher for prior panelists, and for new panelists preparing to conduct seminars.

CDR has also developed a model of in-service training for registered nurses and pediatric nurse practitioners in Virginia through an OSEP four year demonstration grant. This model is built on the successful CFIT model of in-service training for physicians and adapted material from the CFIT independent study manual for use with nurses. Joint training of nurses and physicians was piloted in Virginia with promising results for future training efforts. At that seminar, physicians and nurses made plans for joint referrals, joint screening and assessment, and joint follow-up on children and families referred. Many states have expressed interest in inviting nurses and other health care professionals to CFIT Physicians training, another promising sign of the continued and expanding impact of this project.

XI. ASSURANCES

This statement serves as an assurance that the original and two copies of the full final report have been sent to Ms. Rose Sayer, Office of Special Education, U.S. Department of Education. One copy of the full final report has been sent to the ERIC Clearinghouse on Handicapped and Gifted Children. In addition, copies of the title page and abstract have been

sent to Peggy Hensley, NECTAS Coordinating Office.

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APPENDIX A

CFIT Competencies

Competencies on which Curriculum Is Based and Page References to Corresponding Sections of the Manual

Child Find	Page References
The primary care physician will:	
1. display an awareness of the importance of developmental and family issues	p. 2-1 to 2-8
2. know the components and intent of P. L. 105-17 and the policies and procedures of their state relative to screening, identification, and referral of children to Part C services	p. 3-1 to 3-6 p. 4-1 to 4-5
3. know the criteria for eligibility within their state for Part C services.	p. 4-3, 4-4; p. 6-8, 6-9, 6-10
4. be able to identify factors placing a child at-risk for developmental delay with particular emphasis on those factors making a child eligible for Part C services	p. 4-3, 4-4 p. 5-8 to 5-14
5. have and regularly employ strategies in a variety of settings (e.g., newborn nursery, hospital stays, well-child office visits) for the observation and identification of children who have disabilities, developmental delays, or who may be at-risk for delay	p. 5-8 to 5-14
6. be skilled in the use and interpretation of developmental screening techniques	p. 5-14 to 5-21
7. have a strategy for providing periodic screening in the context of office-based primary care including a. developmental screening of all infants; and b. periodic rescreening for all children.	p. 5-7 to 5-14
8. know and use the procedures for referring infants and toddlers to the Part C services within the community, and know the variety of community resources available for infants and toddlers who may be eligible	p. 5-14 p. 5-19 to 5-30 State Directory Appendix B
9. have and regularly use a variety of strategies to enhance linkages and coordination of care including making and receiving referrals to and from secondary and tertiary care settings, risk registries, and other relevant consultants	p. 5-14 p. 5-22 to 5-30 p. 5-33 to 5-40 State Directory Appendix B

Child Development Resources
P.O. Box 280 • Norge, Virginia 23127

Competencies on which Curriculum Is Based and Page References to Corresponding Sections of the Manual

Child Find (continued)	Page References
10. have and regularly use a variety of strategies for increasing family awareness of developmental milestones, resources for assessment, the importance of early identification, potential for improved outcomes	p. 5-8 to 5-14 p. 5-19 to 5-21
11. have and regularly use a variety of formal and informal interview techniques to elicit family concerns and observation regarding the development of their infants and toddlers	p. 5-8 to 5-14 p. 5-15 to 5-17 p. 7-1 to 7-24
12. have and use communication skills and strategies appropriate for ensuring family understanding of medical information, including consultant findings, and for ensuring their involvement in decisions about referral to Part C or further evaluation and intervention	p. 5-19 to 5-26 p. 5-33 to 5-40
13. have strategies and routines for the acquisition of new state of the art knowledge base related to this area	p. 5-31

Assessment

The primary care physician will:

1. be aware of options for his/her own involvement in assessment, diagnosis, and management of the child's health needs based on interests and skills, and be able to communicate clearly that degree of involvement to parents or caregivers	p. 6-14 to 6-15
2. be skilled in interpreting diagnostic information and implications of diagnosis with family, including eliciting their ideas and concerns	Preface p. 6-24 to 6-27; 6-31 to 6-40
3. know and use resources for obtaining consultation from other Part C providers necessary and be skilled in presenting need and rationale for consultation to family	State Directory Appendix B
4. be able to interpret all findings for the family in an understandable way and involve and support family in decisions related to additional assessment, referral, and intervention	p. 6-5 to 6-7 p. 6-11, 6-12; 6-24 to 6-27

Competencies on which Curriculum Is Based and Page References to Corresponding Sections of the Manual

Assessment (continued)	**Page References**
5. be able to perform longitudinal monitoring of a child to clarify trends of growth or function, when appropriate	p. 5-8 to 5-14 p. 6-8 to 6-15
6. be able to provide family with options for referral and to make appropriate referrals to agencies providing needed services	State Directory Appendix B
7. be able to present information related to the child's medical condition and functional level to family and other team members responsible for development of a plan of intervention	p. 6-14 to 6-15
8. be skilled in formal and informal interview techniques to allow families to share their strengths and needs related to their child's development and provide emotional support in the process	p. 6-5 to 6-7
9. be skilled in formal and informal interview techniques that encourage families to share their own perceptions of their child's problems, strengths, and needs, and that help families clarify those perceptions	p. 6-22 to 6-29 p. 7-4 to 7-10
10. be aware of community resources and have skills in helping families obtain the services they desire	p. 7-7 to 7-9 State Directory Appendix B

Developing and Implementing IFSPs

The primary care physician will:

1. be aware of P. L. 105-17 and of principles of family-centered intervention plans	p. 2-4 p. 3-1 to 3-3; 8-1 to 8-4
2. be able to define and arrange medical consultations required for the child's assessment, diagnosis, and ongoing management in a manner consistent with the self-selected degree of involvement and to maintain communication with consultant	p. 8-9 to 8-11 p. 8-19

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Developing and Implementing IFSPs (continued)	**Page References**
3. know and be able to discuss with a family the value of an IFSP, and know how to initiate or help a family initiate a group process to begin IFSP development	p. 8-1 to 8-11
4. assist family in determining who should be involved in the IFSP process	p. 8-8 to 8-9
5. know the procedure for referral to local early intervention service provider(s) responsible for IFSP development and help family in arranging for their participation	p. 5-14 p. 5-21 to 5-30 State Directory Appendix B
6. be able to communicate, as a member of the IFSP team, the child's medical and health needs either directly or through the parent to the team	p. 6-24 to 6-27 p. 8-9 to 8-13
7. be able to help other members of the IFSP team understand the impact of those conditions on a child's overall development and implications of medical conditions for program planning	p. 8-9 to 8-12
8. assist the family in preparing for the IFSP development, providing support throughout the process, and encouraging the family to be heard and have a principal role in the IFSP development	p. 5-5 to 6-7; 6-22 to 6-23 p. 7-1 to 7-24 p. 8-9 to 8-11
9. present and clarify information gained during assessment about the child's conditions, functional levels, family strengths and needs, in sufficient detail to be useful in the IFSP	p. 6-24 to 6-28 p. 7-3 p. 8-9 to 8-12
10. be able to function as the coordinator or liaison regarding child's health or medical needs, communicating with the child's service coordinator or other person representing the team providing early intervention services	p. 8-18 to 8-19 p. 9-8 to 9-12

Transition	Page References
The primary care physician will:	
1. understand the stress associated with transition from one service to another for the child and for the family	p. 9-2 to 9-4
2. be aware of community-based early intervention systems that may provide services for children leaving the hospital and returning home (see competencies related to child find and referral)	p. 9-8 to 9-11 State Directory Appendix B
3. be aware of the criteria which might lead to the termination of early intervention services and help the family become aware of the possibility of discharge from early intervention	p. 9-11 to 9-14
4. be aware of other services for children leaving early intervention programs and be able to provide information about services to families	p. 9-11 to 9-14 State Directory Appendix B
5. know how to make a referral to public schools for preschool special education services and know the criteria for eligibility	p. 9-11 to 9-14 State Directory Appendix B
6. know the advantages of inclusive placements for children with disabilities, be aware of options for inclusive placements, and be able to communicate that information to families	p. 9-13 p. 9-17 to 9-23
7. participate as a member of the team in developing plans for transition to be incorporated in the IFSP	p. 9-4 to 9-7
8. have communication skills needed to encourage and support families in developing plans for transition to be incorporated in the IFSP	p. 9-4 to 9-7
9. have communication skills needed to encourage and support families and children during the transition to services after early intervention	p. 9-4 to 9-7; 9-13 to 9-14 p. 9-17 to 9-23
10. be aware of the need for and value of service coordination after early intervention	p. 9-14
11. know other resources for service coordination in the community and provide that information to families	State Directory Appendix B

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Appendix A

Adapted from:

American Academy of Pediatrics (1998, Nov.) Proceedings from a National Conference on Public Law 99-457: Physician Participation in the Implementation of the Law. Washington, D.C.

APPENDIX B

Accreditation Statements

The University of Virginia School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians

The University of Virginia School of Medicine designates this educational activity for up to 8 hours for independent study in Category 1 of the Physician's Recognition Award of the American Medical Association. Each physician should claim only those hours of credit that he/she actually spends in the educational activity

This continuing medical education activity (independent study) has been reviewed by the American Academy of Pediatrics and is acceptable for 8 AAP credit hours. These credits can be applied toward the PREP Education Award available to Fellows and Candidate Fellows of the American Academy of Pediatrics.

This program (CFIT Introductory Seminar) has been reviewed and is acceptable for up to 2.5 Prescribed credit hours by the American Academy of Family Physicians. This program (CFIT Independent Study) has been reviewed and is acceptable for up to 6 Prescribed credit hours by the American Academy of Family Physicians. Term of approval is for one year from beginning distribution date of January 1, 2000 with option to request yearly renewal

APPENDIX C

CFIT Site Selection, LPG Action Plan, Outreach Replication Agreement, Introductory Seminar Agenda

CRITERIA

- Support for replication activities from Part H office
- Support for replication activities from state chapters of the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP) or commitment from representative to work to generate that support
- Commitment from Part H and Academy representatives to participate as members of the leadership group for planning replication
- Willingness to assist in identifying other key personnel to assist in planning activities
- Commitment to providing training through an interdisciplinary team that includes physicians, early intervention personnel, and parents, and assisting with arrangements that make that possible (child care, travel, stipends, etc.)
- Commitment to making training accessible to physicians whose patients live in Empowerment Zones and Enterprise Communities
- Willingness of Part H office to assist in gathering state-specific information needed to customize the Independent Study Manual
- Willingness to secure financial resources to support cost of replication including cost sharing of CFIT staff travel
- Commitment to data collection for evaluation of CFIT replication effectiveness

LEADERSHIP PLANNING GROUP ACTION PLAN

ACTIVITIES	DECISIONS/STRATEGIES	PERSONS RESPONSIBLE	TIMELINES
I. STATE PLANNING			
A. Develop replication plan for state			
1. Identify and secure financial resources to support cost of replication			
2. Determine projected number of community physicians to be trained in the state, including physicians providing care to children from cultural, linguistic, or racial minority groups			
3. Determine the number of introductory seminars for community physicians to be held, locations, projected dates, time, costs, registration fee, if any			
4. Determine how many interdisciplinary training teams will be formed			

LEADERSHIP PLANNING GROUP ACTION PLAN

ACTIVITIES	DECISIONS/STRATEGIES	PERSONS RESPONSIBLE	TIMELINES
5. Determine process for selecting regional interdisciplinary training team members (nomination or other) ▸ Physicians (2) ▸ Early intervention providers (1) ▸ Parents (2) ▸ Moderator (1) ▸ MD leader (1)			
B. Customize Independent Study Manuals to reflect state Part H regulations			
1. Identify Part H or other appropriate liaison contact to work with CFIT staff			
2. Respond to state-specific questions for customizing manual			
3. Select state and local resource lists for inclusion in manual			
4. Approve draft of state specific pages developed by CFIT			

LEADERSHIP PLANNING GROUP ACTION PLAN

ACTIVITIES	DECISIONS/STRATEGIES	PERSONS RESPONSIBLE	TIMELINES
5. Secure letters of endorsement from State Chapter Presidents of AAP and AAFP			
6. Secure inserts for manuals (approximately $8.50/set; CFIT will provide list of suppliers and addresses)			
7. Purchase 2" white view binders (@ $4.50 each)			
8. Purchase audiotapes to accompany manuals ($10.50/set, includes shipping) and covers and spines (@ $1.50± per set) from CFIT			
9. Oversee duplication (approximately $14/manual) and assembly of manuals			
C. Plan Train-the-Trainer Seminar			
1. Select team to conduct state-wide Train-the-Trainer Seminar: MD leader, panel, moderator			

LEADERSHIP PLANNING GROUP ACTION PLAN

ACTIVITIES	DECISIONS/STRATEGIES	PERSONS RESPONSIBLE	TIMELINES
2. Select date, site, and make other logistical arrangements (food, AV equipment, etc) for the Train-the-Trainer Seminar			
3. Notify regional training team members of their nomination/selection as trainers for the regional seminars			
4. Prepare team for conducting Train-the-Trainer Seminar			
D. Identify & invite community physicians and others to attend Regional Introductory Seminars			
1. Determine the mailing list for invitations to physicians and obtain mailing lists/labels from: ▸ State Chapter AAP ▸ State Chapter AAFP ▸ Medical societies ▸ Other mechanisms for extending invitations to physicians			
2. Develop letter of invitation/brochure (brochure must be approved by UVA CME office prior to mailing)			

LEADERSHIP PLANNING GROUP ACTION PLAN

ACTIVITIES	DECISIONS/STRATEGIES	PERSONS RESPONSIBLE	TIMELINES
3. Send letter on AAP and AAFP letterhead respectively, signed by appropriate president of state chapter			
4. Determine the mailing list for invitations to representatives of local EI service providers and others			
II. CFIT TRAINING: Train-the-Trainer & Regional Introductory Seminars			
A. Conduct the Train-the-Trainer Seminar (full day)			
1. Registration a. Mail registration brochure b. Track registration c. Prepare/mail registration confirmation packet ▸ Adapt confirmation letters ▸ Prepare coded pre-evaluation packets ▸ Mail reading materials (preface through section 1) and pre-evaluation packets			

LEADERSHIP PLANNING GROUP ACTION PLAN

ACTIVITIES	DECISIONS/STRATEGIES	PERSONS RESPONSIBLE	TIMELINES
2. Coordinate on-site registration process ▸ Collect pre-evaluations ▸ Disseminate registration materials ▸ Name tags ▸ Manual and audiotapes ▸ Agenda ▸ Objectives			
3. Collect seminar evaluation forms			
B. Conduct Regional Introductory Seminars			
1. Registration a. Mail registration brochure b. Track registration c. Prepare/mail registration confirmation packet ▸ Adapt confirmation letters ▸ Prepare coded pre-evaluation packets ▸ Mail reading materials (preface through section 1) and pre-evaluation packets			

LEADERSHIP PLANNING GROUP ACTION PLAN

ACTIVITIES	DECISIONS/STRATEGIES	PERSONS RESPONSIBLE	TIMELINES
2. Coordinate onsite registration process ▸ Collect pre-evaluations ▸ Disseminate registration materials - Name tags - Manual and audiotapes - Agenda - Objectives			
3. Collect seminar evaluation forms and forward to CFIT			
4. Submit CME paperwork requirements for the Train-the-Trainer Seminar and each Introductory Seminar ▸ Sample brochure (must be approved by UVA CME Director prior to mailing: 4 copies) ▸ Sample agenda (4 copies) ▸ M.D. and early intervention presenters' Vitae (2 copies) ▸ Disclaimer forms signed by all presenters (3 copies) ▸ Registration list ▸ Seminar dates & locations ▸ Evaluation forms			

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LEADERSHIP PLANNING GROUP ACTION PLAN

ACTIVITIES	DECISIONS/STRATEGIES	PERSONS RESPONSIBLE	TIMELINES
II-B-4 continued: Costs (CFIT will forward payments to AAP, AAFP and UVA. State will reimburse CFIT) ‣ AAP $100/Train-the-Trainer & Introductory Seminars ‣ AAFP $10/Train-the-Trainer & Introductory Seminars ‣ UVA $20/Train-the-Trainer & Introductory Seminars			
III. Independent Study			
A. Distribute manuals and tapes at Train-the-Trainer and Regional Introductory Seminars			
B. Designate contact for technical assistance and follow-up ‣ Send letter to remind participants: - That technical assistance is available - The timelines for completing the Independent Study - To complete and return their post-evaluations			
C. Collect post-knowledge and competency measures and independent study questionnaires			

LEADERSHIP PLANNING GROUP ACTION PLAN

ACTIVITIES	DECISIONS/STRATEGIES	PERSONS RESPONSIBLE	TIMELINES
IV. EVALUATION **Note:** Several evaluation activities have been identified within the appropriate section for that task. The following list summarizes the LPG responsibilities regarding evaluation.			
A. Duplicate pre and post measures, seminar questionaires, and independent study questionaires			
B. Distribute pre and post measures, seminar questionaires, and independent study questionaires at the Train-the-Trainer and Introductory Seminars			
C. Collect pre measures and seminar questionaires at the Train-the-Trainer and Introductory Seminars			
D. Follow-up with physicians and collect post measures and independent study questionaires			
E. Send pre and post measures, independent study questionnaires, and seminar questionnaires to CFIT			

CARING FOR INFANTS AND TODDLERS WITH DISABILITIES:
NEW ROLES FOR PHYSICIANS (CFIT)
OUTREACH REPLICATION AGREEMENT

This agreement is between Child Development Resources' CFIT Outreach Project and the Leadership Planning Group.

I. CFIT OUTREACH PROJECT COMMITMENT

CFIT Outreach will provide the following services to assist the Leadership Planning Group in replicating the CFIT model of inservice training for physicians:

- provision of sample independent study manual, including audiotapes, to leadership planning group members and assistance in determining who how to customize for state-specific information
- assistance in identifying an interdisciplinary training team and preparing them to conduct the Introductory Seminar
- assistance in implementing Independent Study and Technical Support
- provision of samples of data collection forms for evaluating replication activities
- continuous technical support needed to ensure successful replication of the CFIT model
- other, as appropriate

II. LEADERSHIP PLANNING GROUP COMMITMENT

The Leadership Planning Group agrees to replicate the CFIT model of inservice training for physicians and agrees to:

- provide information needed to customize the Independent Study Manual
- identify and secure financial resources to support cost of replication
- ensure that training is accessible to physicians whose patients live in Empowerment Zones and Enterprise Communities
- ensure that training is provided through an interdisciplinary team to include physicians, other early intervention personnel, and parents
- assist in evaluating CFIT Outreach through data collection
- other, as negotiated

NAME	AFFILIATION	DATE

Caring for Infant and Toddlers with Disabilities: New Roles for Physicians

Introductory Seminar

[LOCATION]

[DATE]
[TIME]

AGENDA

6:00 - 6:15	Registration/Complete Pre-Evaluation Measures (physicians only)	
6:15 - 6:30	Welcome and Introductions	**[NAME(S)]**
6:30 - 6:45	Philosophical Foundations/ Power of the Physician	**[NAME]**
6:45 - 7:30	Interdisciplinary Panel Addressing Child Find & Assessment	**[NAMES]**
7:30 - 8:00	Learning About Community Resources	**Local Representatives**
8:00 - 8:45	Interdisciplinary Panel Addressing IFSP & Transition	**[NAMES]**
8:45 - 9:00	Evaluation/Wrap Up	

Dinner will be served

APPENDIX D

Independent Study Manual Introductory Materials

Caring

for Infants and Toddlers with Disabilities (CFIT)
A Manual for Physicians

Francine G. Gallagher, M.Ed.
Corinne W. Garland, M.Ed.
Barbara A. Kniest, M.Ed.
Andrea C. Quigley, M.S.
Child Development Resources

with consultation from

Robert Boyle, M.D.
Susan Anderson, M.D.
University of Virginia School of Medicine

Third edition 1998

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Caring for Infants and Toddlers with Disabilities is a continuing medical education project developed and implemented by **Child Development Resources, Inc**. The project is sponsored by the University of Virginia School of Medicine. Support for this project is provided by grant number H024D70019-98 from the U.S. Department of Education. Points of view or opinion do not, however, necessarily represent official views or opinions of the Department of Education.

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Child Development Resources
Caring for Infants and Toddlers with Disabilities (CFIT)
Post Office Box 280
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Revised from the 2nd edition *Caring for Infants and Toddlers with Disabilities: A Manual for Physicians*. Authors: Francine G. Gallagher, M.Ed.; Corinne W. Garland, M.Ed.; and Barbara A. Kniest, M.Ed.

Caring for Infants and Toddlers with Disabilities: A Self-Study Manual for Physicians (Seklemian, P., Scott, F. G., and Garland, C. W.) was originally released in May, 1993. [The 2nd edition was reviewed and approved in August 1995.]

This independent study manual was planned and produced in accordance with ACCME Essentials.

All reprinted materials contained in this manual have been used with permission from publishers.

Accreditation Statement

The University of Virginia School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

The University of Virginia School of Medicine designates this educational activity for up to 8 hours for independent study in Category 1 of the Physician's Recognition Award of the American Medical Association. Each physician should claim only those hours of credit that he/she actually spends in the educational activity.

This continuing medical education activity (independent study) has been reviewed by the American Academy of Pediatrics (AAP) and is acceptable for up to 8.0 AAP credit hours. These credits can be applied toward the PREP Education Award available to Fellows and Candidate Fellows of the American Academy of Pediatrics.

This program (CFIT Introductory Seminar) has been reviewed and is acceptable for up to 2.5 Prescribed credit hours by the American Academy of Family Physicians. This program (CFIT Independent Study) has been reviewed and is acceptable for up to 6 Prescribed credit hours by the American Academy of Family Physicians. Term of approval is for one year from beginning distribution date of January 1, 1999, with option to request yearly renewal.

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11. **Appendix B: State and National Resources**

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Acknowledgments

CDR's Caring for Infants and Toddlers: New Roles for Physicians (CFIT) would like to acknowledge Illinois' recognition of the importance of physician participation in a statewide system of early intervention for young children with disabilities and their families.

The following members of the Illinois CFIT leadership Planning Group actively participated in and provided valuable insight to the design and implementation of Illinois' replication of the CFIT model of inservice training.

Carol Boyke

Claudia Fabian

Garry Gardner, M.D.

Carol Harvey

Miriam Kalichman, M.D.

Nancy Keck, M.D.

Kay Komie

Loretta Lattyak

Mary Miller

Grace Ortiz

Sharon Pike

Rosita Pildes, M.D.

Anne Shannon

Philip Ziring, M.D.

Ushanalini Vasan, M.D.

Preface

Striking a balance between hope and realism is a challenge for those working with infants and their parents. Recently, I was asked to evaluate an infant with microcephaly (small head size) noted at birth. The baby's pediatrician followed her for well-child care for several months until it became clear that there were serious questions about vision and general development. Her parents were extremely anxious about the possibility of problems and refused further evaluation for many weeks after the pediatrician broached the subject. Finally, the parents agreed to a limited "second look" by a developmental pediatrician at a tertiary care center.

One look confirmed my suspicions based on the history I had received beforehand. Martha, now 4 months old, displayed little visual or auditory attention although she seemed to see and hear. She did not smile or interact socially, even though her parents were attentive and obviously attached to her. Her head circumference had changed little from birth.

During my interview, Martha's mother kept interjecting questions about things she might have done wrong during the pregnancy although her prenatal care and behavior were exemplary. My recommendations for further testing—magnetic resonance (MR) imaging of the brain, auditory brainstem evoked responses, electroencephalography, and ophthalmologic examination—were met with resistance, partly out of fear of possible harm and discomfort and partly out of fear of the results. It took several weeks for the parents to consent.

As expected, the MR study was abnormal, showing a failure of neurons to migrate completely to the cerebral cortex (lissencephaly). Furthermore, there was agenesis of the corpus callosum. The other tests were unremarkable.

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I knew that the follow-up interpretive with Martha's parents was going to be difficult (i.e., emotionally charged). My intent was to refer them to genetics for counseling and to the community early intervention program. The more difficult task would be balancing hope and realism. Clearly, Martha would have serious developmental problems, but the exact extent could not be determined at this age.

Wolraich (1987) has written about communication of distressful information to parents. Several points he has made are useful for situations such as the one described above, whatever the setting:

- *Allow parents to feel free to discuss concerns and feelings. Do not try to relieve guilt by statements such as "You shouldn't feel guilty because..." Professionals may acknowledge their own discomfort when conveying the information.*
- *Discuss possible reactions from other family members. It may be helpful to provide information to other supportive people, such as friends or close relatives, if the parents so desire.*
- *In the case of initial discussions, parents may not remember many of the details.*
- *Additional sessions or tape recordings are helpful.*
- *Terms such as cerebral palsy, pervasive developmental disorder, or developmental delay frequently are misunderstood. Carefully and repeatedly defining new words, using visual aids, pausing for reactions or questions, and providing written take-home materials can be useful.*
- *Rather than focusing on parents' acceptance of the child's condition, discussion should be directed toward what can be done to help. One pitfall is to imply that a permanent condition can be cured or will go away. Parents need to understand the limitations, as well as the potential benefits, of various medical, educational, therapeutic, and psychosocial interventions.*

Martha's parents are now mulling over the referral to the early intervention program. I expect they

will choose to engage these services in hopes of ameliorating, if not curing, Martha's problems. They seemed most relieved to hear that brain abnormalities are not fatal, and they continue to cling to the hope that their child's developmental problems will be minor. My writing of this preface has reinforced in my mind the need to communicate well with the early intervention program.

The process of supporting Martha and her parents only began with my contact; in fact, communication of diagnosis is inevitably somewhat destructive. The most important work will continue in the community. By sharing what I have learned about Martha and her parents with the community service providers, the flow of support should continue and build without interruption.

—*James A. Blackman, M.D., M.P.H.*

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Reference

Wolraich, M. (1987). General management techniques. In: M.L. Wolraich, (Ed.) *The practical assessment and management of children with disorders of development and learning.* Chicago, IL: Year Book Medical.

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Notes

Introduction

Historical Perspective

Caring for Infants and Toddlers with Disabilities: New Roles for Physicians (CFIT) is a model of inservice training designed to ensure that physicians have the information and skills needed to be full participants in community systems of early intervention. The CFIT model was developed by **Child Development Resources (CDR)** working in collaboration with the Virginia Chapters of the **American Academy of Pediatrics** and the **American Academy of Family Physicians** and colleagues at the **University of Virginia School of Medicine**.

This model was developed in response to training needs identified through a survey of pediatricians (Scott, 1990; Gallagher and Garland, 1994) and in recognition of the importance of physician involvement in statewide systems of early intervention for young children with disabilities and their families.

Funding to develop the CFIT model was provided by the U. S. Department of Education, Office of Special Education Programs (OSEP), Early Education Program for Children with Disabilities (EEPCD) for a three year period beginning in 1991. During that phase, the *Caring for Infants and Toddlers with Disabilities* manual was developed and introduced to 200 physicians in Virginia. Training content was based on a set of competencies developed by the American Academy of Pediatrics and adapted for use by the CFIT project.

In 1994 and 1997, funding was awarded to CFIT Outreach to assist other states in providing this inservice program to physicians in their states. Since 1994, over 750 physicians in nine states and territories have participated in CFIT training. The CFIT Outreach model includes three components: State Planning, Introductory Seminars, and Independent Study.

📖 A copy of an article describing this survey can be found at the end of this Introduction.

Design and Use of This Manual

Caring for Infants and Toddlers with Disabilities: A Manual for Physicians includes nine sections regarding the efficacy of early intervention, the philosophical basis for and legislative history of early intervention, and the process that a family experiences while working with the early intervention system. The role of the physician as an important member of the early intervention team is described throughout.

The manual is divided into white pages and colored pages. The white pages contain information that is pertinent to physicians practicing anywhere in the U.S. Within the white pages, this symbol, ▶, indicates that additional information specific to the early intervention system in your state is contained in the colored pages that follow.

The information in these pages has been provided by representatives of the early intervention system in your state. Each section may also include supplemental readings and practice activities. This symbol, 📖, indicates that additional information may be found in the supplemental reading for that section or elsewhere in the manual. Additional information and resources are included in the appendices.

This manual is designed for independent study. A set of accompanying audiotapes covering child find, assessment, IFSP, and transition may be used as a preview or summary of the reading material. Two assessments are used with this manual: one that measures your current knowledge of early intervention, and one self assessment that rates your perception of the degree to which you have mastered the competencies recommended by the American Academy of Pediatrics. Your self assessment may help guide your study. These two measures have been developed to assess the effectiveness of the independent study.

Appendix A references each competency to information in the manual to make it easy for you to find the information you need.

Upon completion of the independent study phase, you will be asked to complete the knowledge and competency measures again as a self assessment of your progress.

References

Scott, F. (1990). A statewide survey of pediatricians on early identification and early intervention. Richmond, VA: Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, Part H Office.

Gallagher, F. G. and Garland, C. W. (1994). What do physicians want to know? A statewide survey report of physicians' needs for information about early intervention. In Darling, R. B. and Peter, M. I. (eds) Families, physicians, and children with special health needs. Westport, CT: Auburn House. p. 149-170.

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Notes

APPENDIX E

Evaluation Measures

The competencies below are adapted from a set of competencies developed by the American Academy of Pediatrics. Please score your need for further education in each area of competency.

RATING SCALE

Rate the extent to which you believe you have mastered each of the following competencies by circling your choice.

1= I need a great deal more information or training
3 = I need some more information or training
5 = I have full mastery

A. CHILD FIND	Level of Competency
1. display an awareness of the importance of developmental and family issues	1 2 3 4 5
2. know the components and intent of IDEA and the policies and procedures of your state relative to screening, identification, and referral of children to Part C services	1 2 3 4 5
3. know the criteria for eligibility within your state for Part C services	1 2 3 4 5
4. be able to identify factors placing a child at-risk for developmental delay with particular emphasis on those factors making a child eligible for Part C services	1 2 3 4 5
5. have and regularly employ strategies in a variety of settings (e.g., newborn nursery, hospital stays, well-child office visits) for the observation and identification of children who have disabilities, developmental delays, or who may be at-risk for delay	1 2 3 4 5
6. be skilled in the use and interpretation of developmental screening techniques	1 2 3 4 5
7. have a strategy for providing periodic screening in the context of office-based primary care including a. developmental screening of all infants; and b. periodic rescreening for all children	 1 2 3 4 5 1 2 3 4 5
8. know and use the procedures for referring infants and toddlers to the Part C services within the community, and know the variety of community resources available for infants and toddlers who may be eligible	1 2 3 4 5
9. have and regularly use a variety of strategies to enhance linkages and coordination of care including making and receiving referrals to and from secondary and tertiary care settings, risk registries, and other relevant consultants	1 2 3 4 5
10. have and regularly use a variety of strategies for increasing family awareness of developmental milestones, resources for assessment, the importance of early identification, potential for improved outcomes	1 2 3 4 5

11. have and regularly use a variety of formal and informal interview techniques to elicit family concerns and observation regarding the development of their infants and toddlers	1 2 3 4 5
12. have and use communication skills and strategies appropriate for ensuring family understanding of medical information, including consultant findings, and for ensuring their involvement in decisions about referral to Part C or further evaluation and intervention	1 2 3 4 5
13. have strategies and routines for the acquisition of new state of the art knowledge base related to this area	1 2 3 4 5
B. ASSESSMENT	
1. be aware of options for your own involvement in assessment, diagnosis, and management of the child's health needs based on interests and skills, and be able to communicate clearly that degree of involvement to parents or caregivers	1 2 3 4 5
2. be skilled in interpreting diagnostic information and implications of diagnosis with family, including eliciting their ideas and concerns	1 2 3 4 5
3. know and use resources for obtaining consultation from other Part C providers necessary and be skilled in presenting need and rationale for consultation to family	1 2 3 4 5
4. be able to interpret all findings for the family in an understandable way and involve and support family in decisions related to additional assessment, referral, and intervention	1 2 3 4 5
5. be able to perform longitudinal monitoring of a child to clarify trends of growth or function, when appropriate	1 2 3 4 5
6. be able to provide family with options for referral and to make appropriate referrals to agencies providing needed services	1 2 3 4 5
7. be able to present information related to the child's medical condition and functional level to family and other team members responsible for development of a plan of intervention	1 2 3 4 5
8. be skilled in formal and informal interview techniques to allow families to share their strengths and needs related to their child's development and provide emotional support in the process	1 2 3 4 5
9. be skilled in formal and informal interview techniques that encourage families to share their own perceptions of their child's problems, strengths, and needs, and that help families clarify those perceptions	1 2 3 4 5
10. be aware of community resources and have skills in helping families obtain the services they desire	1 2 3 4 5

C. DEVELOPING/IMPLEMENTING IFSPs	
1. be aware of IDEA and of principles of family-centered intervention plans	1 2 3 4 5
2. be able to define and arrange medical consultations required for the child's assessment, diagnosis, and ongoing management in a manner consistent with the self-selected degree of involvement and to maintain communication with consultant	1 2 3 4 5
3. know and be able to discuss with a family the value of an IFSP, and know how to initiate or help a family initiate a group process to begin IFSP development	1 2 3 4 5
4. assist family in determining who should be involved in the IFSP process	1 2 3 4 5
5. know the procedure for referral to local early intervention service provider(s) responsible for IFSP development and help family in arranging for their participation	1 2 3 4 5
6. be able to communicate, as a member of the IFSP team, the child's medical and health needs either directly or through the parent to the team	1 2 3 4 5
7. be able to help other members of the IFSP team understand the impact of those conditions on a child's overall development and implications of medical conditions for program planning	1 2 3 4 5
8. assist the family in preparing for the IFSP development, providing support throughout the process, and encouraging the family to be heard and have a principal role in the IFSP development	1 2 3 4 5
9. present and clarify information gained during assessment about the child's conditions, functional levels, family strengths and needs, in sufficient detail to be useful in the IFSP	1 2 3 4 5
10. be able to function as the coordinator or liaison regarding child's health or medical needs, communicating with the child's service coordinator or other person representing the team providing early intervention services	1 2 3 4 5
D. TRANSITION	
1. understand the stress associated with transition from one service to another for the child and for the family	1 2 3 4 5
2. be aware of community-based early intervention systems that may provide services for children leaving the hospital and returning home	1 2 3 4 5
3. be aware of the criteria which might lead to the termination of early intervention services and help the family become aware of the possibility of discharge from early intervention	1 2 3 4 5

4. be aware of other services for children leaving early intervention programs and be able to provide information about services to families	1 2 3 4 5
5. know how to make a referral to public schools for preschool special education services and know the criteria for eligibility	1 2 3 4 5
6. know the advantages of integrated placements for children with disabilities, be aware of options for integrated placements, and be able to communicate that information to families	1 2 3 4 5
7. participate as a member of the team in developing plans for transition to be incorporated in the IFSP	1 2 3 4 5
8. have communication skills needed to encourage and support families in developing plans for transition to be incorporated in the IFSP	1 2 3 4 5
9. have communication skills needed to encourage and support families and children during the transition to services after early intervention	1 2 3 4 5
10. be aware of the need for and value of service coordination after early intervention	1 2 3 4 5
11. know other resources for service coordination in the community and provide that information to families	1 2 3 4 5

THANK YOU!

CARING FOR INFANTS AND TODDLERS WITH DISABILITIES: NEW ROLES FOR PHYSICIANS

Early Intervention Knowledge Measure (Pre)

State: _____ Date: _____

For each multiple choice question/statement, please circle the best answer.

CHILD FIND

1. Which of the following activities might be considered part of the child find effort for early intervention?
   1. developmental screening provided in physicians' offices
   2. developmental screening provided by early intervention program personnel
   3. public service television announcements about early intervention services
   4. a multidisciplinary team evaluation

   a) 1
   b) 1 and 2
   c) 1, 2, and 4
   d) all of the above

2. Periodic developmental screening using a formal screening instrument is:
   1. a standard of health care for infants and toddlers
   2. an ideal that busy physicians should try to work into their office routines
   3. recommended every 6 months
   4. recommended at birth, 2, 4, 6, 9, 12, 15, and 18 months, and then annually until 6 years

   a) 1
   b) 1 and 3
   c) 2
   d) 1 and 4

3. When screening results indicate the need for a further evaluation, physicians should help families consider the following options:
   1. wait until the next routinely scheduled screening
   2. refer the child for a full developmental evaluation
   3. refer the child for developmental monitoring by an early intervention program
   4. make other referrals the family might need

   a) 1
   b) 2
   c) 3
   d) all of the above

4. In determining whether or not a child should be referred for a further evaluation, a physician should consider:
   1. screening results
   2. observation
   3. medical history
   4. parent preference

   a) 1
   b) 1, 2, and 3
   c) 1 and 3
   d) all of the above

ASSESSMENT

5. When a child has a clearly identified disability, the following steps are necessary before early intervention services can begin:
   1. screening by a physician or other professional
   2. a multidisciplinary team evaluation
   3. referral to the early intervention team serving the community in which the family lives

   a) 2 c) 3
   b) 1 and 2 d) all of the above

6. When a parent and professional agree that a referral for an evaluation and assessment are needed, which of the following are true:
   1. the referral must be accompanied by a diagnosis
   2. the referral should, with parent permission, be accompanied with all necessary medical information
   3. the referral must be made within two working days
   4. the family must have health insurance or another form of payment for the evaluation

   a) 1 and 4 c) 2 and 3
   b) 2 d) 2 and 4

7. In the context of early intervention, which of the following are true:
   1. an evaluation by the early intervention team is always needed to determine a child's eligibility for early intervention services
   2. early intervention services may begin without an evaluation for children who have a clearly identified disability or condition known to result in developmental delay
   3. a multidisciplinary evaluation team need only to include professionals from two or more disciplines
   4. evaluation and assessment must be provided by a team involving professionals from two or more disciplines and the family

   a) 1 c) 2 and 4
   b) 1 and 4 d) 1 and 3

8. Once a physician has referred a child to early intervention, which of the following are true:
   1. the physician has an important role in assessment that includes,with family permission, sharing medical information
   2. the physician can, with parent permission, consult with the team by phone or can attend the assessment
   3. a description of the child's current health status, vision, and hearing are required components of the early intervention team assessment
   4. other team members do not need and will not understand information about medications or medical history

   a) 1 c) 1, 2, and 3
   b) 1 and 2 d) 4

9. In the context of early intervention, which of the following are true about the multidisciplinary team assessment:
   1. a major purpose of the assessment is to answer questions the family has about their child's development
   2. the family has an important role in deciding who needs to be on the assessment team
   3. the assessment results are the basis for early intervention services to be provided
   4. the assessment results and family concerns, resources, and priorities are the basis for the early intervention services to be provided

   a) 1 and 4 c) 3 and 4
   b) 1 and 3 d) 1, 2, and 4

DEVELOPING/IMPLEMENTING IFSPs

10. An Individualized Family Service Plan is:
    1. a written plan that is required by law and that is a statement of the goals of early intervention, the services to be provided, and the outcomes to be accomplished
    2. a legal document that belongs to the early intervention system
    3. a family-owned plan, developed with and for the family and shared only with their permission
    4. a plan that should, with parent permission, be monitored by the physician and changed by the team in response to the health and medical status of the child

    a) 1 and 4 c) 1, 3, and 4
    b) 1, 2, and 4 d) 3 and 4

11. The physician's role in the IFSP process includes which of the following?
    1. helping families identify their concerns, priorities, and resources
    2. sharing information with the family and, with permission, with other team members about health-related issues that should be addressed in the plan
    3. helping families identify services they might need
    4. with family permission, reviewing the plan to ensure that health-related issues are adequately addressed

    a) 1 and 2 c) 2, 3, and 4
    b) 2 and 3 d) all of the above

12. Service coordination in the context of early intervention is:
    1. the same as health care coordination and the physician's responsibility
    2. a continuous process of linking and monitoring early intervention services that are included in the IFSP
    3. provided without cost to families
    4. provided by a temporary service coordinator at the time of referral

    a) 1 c) 2 and 4
    b) 2 d) 2, 3, and 4

TRANSITION

13. During transitions or discharge planning, a physician can be especially helpful to a family by:
    1. giving them lots of reading materials
    2. giving families the information they need to consider next placements
    3. helping families decide whether the health-related services proposed for the next placement are adequate and appropriate
    4. making timely referrals of children newly discharged from hospital settings to community-based early intervention services

    a) all of the above
    b) 2, 3, and 4
    c) 3 and 4
    d) 4

14. A child may receive public school early childhood special education services if:
    1. the child is age two by September 30th of the school year
    2. the child is determined eligible by a public school eligibility committee
    3. the child continues to be developmentally delayed
    4. the child's parent wishes

    a) 1 and 2
    b) 1 and 3
    c) 2 and 4
    d) 1, 2, and 4

15. If a child is eligible for public school early childhood special education and related services, those services:
    1. must be specified in a written Individualized Educational Program
    2. must be provided in a special class for children with disabilities
    3. may be provided in a day care, preschool, or Head Start Program
    4. must be based on individual child needs

    a) 1
    b) 2 and 4
    c) 1 and 3
    d) 1, 3, and 4

THANK YOU!

9/3/98

The competencies below are adapted from a set of competencies developed by the American Academy of Pediatrics. Please score your need for further education in each area of competency.

RATING SCALE:

Rate the extent to which you believe you have mastered each of the following competencies by circling your choice.

1= I need a great deal more information or training
3 = I need some more information or training
5 = I have full mastery

A. CHILD FIND	Level of Competency
1. display an awareness of the importance of developmental and family issues	1 2 3 4 5
2. know the components and intent of IDEA and the policies and procedures of your state relative to screening, identification, and referral of children to Part C services	1 2 3 4 5
3. know the criteria for eligibility within your state for Part C services	1 2 3 4 5
4. be able to identify factors placing a child at-risk for developmental delay with particular emphasis on those factors making a child eligible for Part C services	1 2 3 4 5
5. have and regularly employ strategies in a variety of settings (e.g., newborn nursery, hospital stays, well-child office visits) for the observation and identification of children who have disabilities, developmental delays, or who may be at-risk for delay	1 2 3 4 5
6. be skilled in the use and interpretation of developmental screening techniques	1 2 3 4 5
7. have a strategy for providing periodic screening in the context of office-based primary care including a. developmental screening of all infants; and b. periodic rescreening for all children	 1 2 3 4 5 1 2 3 4 5
8. know and use the procedures for referring infants and toddlers to the Part C services within the community, and know the variety of community resources available for infants and toddlers who may be eligible	1 2 3 4 5
9. have and regularly use a variety of strategies to enhance linkages and coordination of care including making and receiving referrals to and from secondary and tertiary care settings, risk registries, and other relevant consultants	1 2 3 4 5

10. have and regularly use a variety of strategies for increasing family awareness of developmental milestones, resources for assessment, the importance of early identification, potential for improved outcomes	1 2 3 4 5
11. have and regularly use a variety of formal and informal interview techniques to elicit family concerns and observation regarding the development of their infants and toddlers	1 2 3 4 5
12. have and use communication skills and strategies appropriate for ensuring family understanding of medical information, including consultant findings, and for ensuring their involvement in decisions about referral to Part C or further evaluation and intervention	1 2 3 4 5
13. have strategies and routines for the acquisition of new state of the art knowledge base related to this area	1 2 3 4 5
B. ASSESSMENT	
1. be aware of options for your own involvement in assessment, diagnosis, and management of the child's health needs based on interests and skills, and be able to communicate clearly that degree of involvement to parents or caregivers	1 2 3 4 5
2. be skilled in interpreting diagnostic information and implications of diagnosis with family, including eliciting their ideas and concerns	1 2 3 4 5
3. know and use resources for obtaining consultation from other Part C providers necessary and be skilled in presenting need and rationale for consultation to family	1 2 3 4 5
4. be able to interpret all findings for the family in an understandable way and involve and support family in decisions related to additional assessment, referral, and intervention	1 2 3 4 5
5. be able to perform longitudinal monitoring of a child to clarify trends of growth or function, when appropriate	1 2 3 4 5
6. be able to provide family with options for referral and to make appropriate referrals to agencies providing needed services	1 2 3 4 5
7. be able to present information related to the child's medical condition and functional level to family and other team members responsible for development of a plan of intervention	1 2 3 4 5
8. be skilled in formal and informal interview techniques to allow families to share their strengths and needs related to their child's development and provide emotional support in the process	1 2 3 4 5

9. be skilled in formal and informal interview techniques that encourage families to share their own perceptions of their child's problems, strengths, and needs, and that help families clarify those perceptions	1 2 3 4 5
10. be aware of community resources and have skills in helping families obtain the services they desire	1 2 3 4 5
C. DEVELOPING/IMPLEMENTING IFSPs	
1. be aware of IDEA and of principles of family-centered intervention plans	1 2 3 4 5
2. be able to define and arrange medical consultations required for the child's assessment, diagnosis, and ongoing management in a manner consistent with the self-selected degree of involvement and to maintain communication with consultant	1 2 3 4 5
3. know and be able to discuss with a family the value of an IFSP, and know how to initiate or help a family initiate a group process to begin IFSP development	1 2 3 4 5
4. assist family in determining who should be involved in the IFSP process	1 2 3 4 5
5. know the procedure for referral to local early intervention service provider(s) responsible for IFSP development and help family in arranging for their participation	1 2 3 4 5
6. be able to communicate, as a member of the IFSP team, the child's medical and health needs either directly or through the parent to the team	1 2 3 4 5
7. be able to help other members of the IFSP team understand the impact of those conditions on a child's overall development and implications of medical conditions for program planning	1 2 3 4 5
8. assist the family in preparing for the IFSP development, providing support throughout the process, and encouraging the family to be heard and have a principal role in the IFSP development	1 2 3 4 5
9. present and clarify information gained during assessment about the child's conditions, functional levels, family strengths and needs, in sufficient detail to be useful in the IFSP	1 2 3 4 5
10. be able to function as the coordinator or liaison regarding child's health or medical needs, communicating with the child's service coordinator or other person representing the team providing early intervention services	1 2 3 4 5
D. TRANSITION	
1. understand the stress associated with transition from one service to another for the child and for the family	1 2 3 4 5

2. be aware of community-based early intervention systems that may provide services for children leaving the hospital and returning home	1 2 3 4 5
3. be aware of the criteria which might lead to the termination of early intervention services and help the family become aware of the possibility of discharge from early intervention	1 2 3 4 5
4. be aware of other services for children leaving early intervention programs and be able to provide information about services to families	1 2 3 4 5
5. know how to make a referral to public schools for preschool special education services and know the criteria for eligibility	1 2 3 4 5
6. know the advantages of integrated placements for children with disabilities, be aware of options for integrated placements, and be able to communicate that information to families	1 2 3 4 5
7. participate as a member of the team in developing plans for transition to be incorporated in the IFSP	1 2 3 4 5
8. have communication skills needed to encourage and support families in developing plans for transition to be incorporated in the IFSP	1 2 3 4 5
9. have communication skills needed to encourage and support families and children during the transition to services after early intervention	1 2 3 4 5
10. be aware of the need for and value of service coordination after early intervention	1 2 3 4 5
11. know other resources for service coordination in the community and provide that information to families	1 2 3 4 5

THANK YOU!

CARING FOR INFANTS AND TODDLERS WITH DISABILITIES: NEW ROLES FOR PHYSICIANS

Early Intervention Knowledge Measure (Post)

State: _____ **Date:** _____

For each multiple choice question/statement, please circle the best answer.

CHILD FIND

1. Which of the following activities might be considered part of the child find effort for early intervention?
   1. developmental screening provided in physicians' offices
   2. developmental screening provided by early intervention program personnel
   3. public service television announcements about early intervention services
   4. a multidisciplinary team evaluation

   a) 1
   b) 1 and 2
   c) 1, 2, and 4
   d) all of the above

2. Periodic developmental screening using a formal screening instrument is:
   1. a standard of health care for infants and toddlers
   2. an ideal that busy physicians should try to work into their office routines
   3. recommended every 6 months
   4. recommended at birth; 2, 4, 6, 9, 12, 15, and 18 months; and then annually until 6 years

   a) 1
   b) 1 and 3
   c) 2
   d) 1 and 4

3. When screening results indicate the need for a further evaluation, physicians should help families consider the following options:
   1. wait until the next routinely scheduled screening
   2. refer the child for a full developmental evaluation
   3. refer the child for developmental monitoring by an early intervention program
   4. make other referrals the family might need

   a) 1
   b) 2
   c) 3
   d) all of the above

4. In determining whether or not a child should be referred for a further evaluation, a physician should consider:
   1. screening results
   2. observation
   3. medical history
   4. parent preference

   a) 1
   b) 1, 2, and 3
   c) 1 and 3
   d) all of the above

ASSESSMENT

5. When a child has a clearly identified disability, the following steps are necessary before early intervention services can begin:
   1. screening by a physician or other professional
   2. a multidisciplinary team evaluation
   3. referral to the early intervention team serving the community in which the family lives

   a) 2 **c)** 3
   b) 1 and 2 **d)** all of the above

6. When a parent and professional agree that a referral for an evaluation and assessment are needed, which of the following are true:
   1. the referral must be accompanied by a diagnosis
   2. the referral should, with parent permission, be accompanied with all necessary medical information
   3. the referral must be made within two working days
   4. the family must have health insurance or another form of payment for the evaluation

   a) 1 and 4 **c)** 2 and 3
   b) 2 **d)** 2 and 4

7. In the context of early intervention, which of the following are true:
   1. an evaluation by the early intervention team is always needed to determine a child's eligibility for early intervention services
   2. early intervention services may begin without an evaluation for children who have a clearly identified disability or condition known to result in developmental delay
   3. a multidisciplinary evaluation team need only to include professionals from two or more disciplines
   4. evaluation and assessment must be provided by a team involving professionals from two or more disciplines and the family

   a) 1 **c)** 2 and 4
   b) 1 and 4 **d)** 1 and 3

8. Once a physician has referred a child to early intervention, which of the following are true:
   1. the physician has an important role in assessment that includes, with family permission, sharing medical information
   2. the physician can, with parent permission, consult with the team by phone or can attend the assessment
   3. a description of the child's current health status, vision, and hearing are required components of the early intervention team assessment
   4. other team members do not need and will not understand information about medications or medical history

   a) 1 **c)** 1, 2, and 3
   b) 1 and 2 **d)** 4

9. In the context of early intervention, which of the following are true about the multidisciplinary team assessment:
   1. a major purpose of the assessment is to answer questions the family has about their child's development
   2. the family has an important role in deciding who needs to be on the assessment team
   3. the assessment results are the basis for early intervention services to be provided
   4. the assessment results and family concerns, resources, and priorities are the basis for the early intervention services to be provided

   a) 1 and 4 **c) 3 and 4**
   b) 1 and 3 **d) 1, 2, and 4**

DEVELOPING/IMPLEMENTING IFSPs

10. An Individualized Family Service Plan is:
    1. a written plan that is required by law and that is a statement of the goals of early intervention, the services to be provided, and the outcomes to be accomplished
    2. a legal document that belongs to the early intervention system
    3. a family-owned plan, developed with and for the family and shared only with their permission
    4. a plan that should, with parent permission, be monitored by the physician and changed by the team in response to the health and medical status of the child

    a) 1 and 4 **c) 1, 3, and 4**
    b) 1, 2, and 4 **d) 3 and 4**

11. The physician's role in the IFSP process includes which of the following?
    1. helping families identify their concerns, priorities, and resources
    2. sharing information with the family and, with permission, with other team members about health-related issues that should be addressed in the plan
    3. helping families identify services they might need
    4. with family permission, reviewing the plan to ensure that health-related issues are adequately addressed

    a) 1 and 2 **c) 2, 3, and 4**
    b) 2 and 3 **d) all of the above**

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    1. the same as health care coordination and the physician's responsibility
    2. a continuous process of linking and monitoring early intervention services that are included in the IFSP
    3. provided without cost to families
    4. provided by a temporary service coordinator at the time of referral

    a) 1 **c) 2 and 4**
    b) 2 **d) 2, 3, and 4**

TRANSITION

13. During transitions or discharge planning, a physician can be especially helpful to a family by:
    1. giving them lots of reading materials
    2. giving families the information they need to consider next placements
    3. helping families decide whether the health-related services proposed for the next placement are adequate and appropriate
    4. making timely referrals of children newly discharged from hospital settings to community-based early intervention services

    a) all of the above
    b) 2, 3, and 4
    c) 3 and 4
    d) 4

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    1. the child is age two by September 30th of the school year
    2. the child is determined eligible by a public school eligibility committee
    3. the child continues to be developmentally delayed
    4. the child's parent wishes

    a) 1 and 2
    b) 1 and 3
    c) 2 and 4
    d) 1, 2, and 4

15. If a child is eligible for public school early childhood special education and related services, those services:
    1. must be specified in a written Individualized Educational Program
    2. must be provided in a special class for children with disabilities
    3. may be provided in a day care, preschool, or Head Start Program
    4. must be based on individual child needs

    a) 1
    b) 2 and 4
    c) 1 and 3
    d) 1, 3, and 4

THANK YOU!

9/3/98